CHAPTER VI

QUALITY ASSURANCE

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OVERVIEW OF DMAS QUALITY ASSURANCE

DMAS Quality Assurance Review is conducted periodically to assure that individuals receiving Medicaid AIDS waiver services continue to require the level of care of a hospital or nursing facility. DMAS review also assures that quality services are being received which are appropriate, cost-effective, and adequate to maintain the recipient in a healthy and safe environment. **If any of these assurances are no longer met, an alternative to Medicaid-reimbursed home and community-based care waiver home support services must be identified.**

DMAS staff perform quality assurance review by the following:

- Review and authorization of the initial plan of care;
- On-site review of the individual recipient's records to review the case manager's documentation which details the recipient's status and the services provided each month;
- Review of the invoices submitted during the month;
- Review of any changes in the services for the home and community-based care waiver individual as reflected in the HIV services plan of care;
- Home visits completed with the recipient to review the satisfaction with the services and the quality of care;
- Provider agency review completed annually to assure the continued compliance with the provider participation standards; and
- On-site review of the direct service providers.

AUTHORIZATION OF THE INITIAL PLAN OF CARE

The Department of Medical Assistance Services will review the assessments and plan of care developed by the pre-admission screening team and process the authorization package for payment of the screening. If AIDS waiver services have been recommended and appear appropriate, the DMAS analyst will notify the screening team in writing of the effective date and amounts of the waiver services which are authorized. A monthly amount of authorized service will then be entered in the Medicaid Management Information System to enable all service providers to bill for the services rendered.

REVIEW OF CHANGES IN THE HIV SERVICES PLAN OF CARE

The case manager will submit changes in the HIV services plan of care to DMAS for entry in the Medicaid Management Information System so that claims can be processed. A letter to the recipient should accompany any plan of care revision submitted to DMAS. DMAS will review all changes to assure that service changes are cost-effective and appropriate. If DMAS finds that the changes are not cost-effective or has some question regarding the necessity of the service, the analyst will contact the case manager to discuss the case further and may schedule a special review if concerns are not answered by this consultation. The change submitted by the case manager will be entered for claims processing; however, DMAS may take action after conducting a special review that may modify the original change submitted by the case manager. DMAS will notify the recipient in writing of any such action, giving 10 working days notice of the effective date of the change and providing the recipient with the right to appeal DMAS' decision.

An AIDS waiver recipient's plan of care must be cost-effective for the recipient's total period of waiver coverage. Therefore, the plan of care may not be cost-effective for some period of time, as long as it is overall cost-effective for the year.

RECIPIENT HOME VISIT

DMAS utilization review staff will conduct a home visit annually to any recipient actively receiving AIDS waiver services. The purpose of the home visit is to:

- Ensure that the amount, duration and scope of the services are appropriate and that the services are being rendered according to the plan of care;
- Address the quality of care issues with the recipient and determine the satisfaction with the services; and
- Ascertain that contacts are being made by service providers and the case manager according to DMAS policy.

The interview with the recipient and the primary caregiver will be conducted in a manner which encourages an open discussion between the recipient, the caregiver, and the DMAS representative. This representative will gather information from the recipient and primary caregiver regarding their satisfaction with services. Satisfaction with services can be determined by a discussion of the recipient's assessment of the:

- Appropriateness of the care plan;

- The continuity of service provided by the service providers;
- The recipient's access to the case manager; and
- The ability to resolve problems in a meaningful manner.

Any problem areas which have been identified should be discussed and a plan for resolution identified. The case manager should be informed of the content of this meeting so that follow-up of any problem areas can be made.

REVIEW OF PROVIDER STANDARDS AND DOCUMENTATION

The provider review will be completed by a DMAS representative on an annual basis. This review is performed to assure continued compliance with Medicaid provider participation standards. Staff credentials will be reviewed for those case managers, nurses, and aides providing services to home and community-based care waiver individuals. Provider documentation will be reviewed for the identification of any quality of care issues such as:

- Lapses in services;
- Staffing the case with unqualified staff;
- Failure to identify and/or follow up on problems; and
- Failure to make the appropriate referrals or to communicate adequately with the family, the case manager, the school, or social services.

It will also be noted if the provider documentation of the hours of service provided and the contacts and visits made, supports the nursing, aide, and case manager documentation.

The Provider Standards and Documentation Form will be completed during this review and a recommendation will be made regarding the contract renewal by the Department of Medical Assistance Services.